Chapter 3: Designing a New Public System

Who Will be Served and How Will They Gain Access

Since the release of *State Plan 2001: Blueprint for Change*, the Division has received many questions about core functions, access to services and target populations. These questions center around core functions as services available to all who need them; core functions versus a minimum, basic benefit package for target populations, often thought of as a set of core services; access to services and a standardized process to access them; and the differences in target populations among disability areas. This chapter provides more detail and attempts to clarify issues that have caused confusion.

CORE FUNCTIONS

The reform statute requires that, within available resources, each local service system must assure that core functions are widely available. There are two types of core functions. One is the direct, individual-specific functions or services of screening, assessment and emergency triage. The other consists of the indirect functions or activities of prevention, education and consultation that are intended to benefit the greater community.

The term core functions does not refer to a minimum, basic set of services for target populations (medication management, acute detoxification or case management, as examples). Core functions are best thought of as pathways to system access. As such, they are closely connected to the concept of uniform portal, a consistent process for gaining access to system services and supports through any of many doors. The range of services to be provided for individuals in target populations referred to as benefit packages, is covered in Chapter 4 of this revision under array of services for target populations.

Screening is a brief standardized appraisal of an individual who is not currently being served within the system in order to determine the nature of the individual's problem and need for services and supports. This includes early periodic screening, diagnosis and treatment (EPSDT) and other federally mandated screening. Both financial and clinical information is gathered to determine next steps. The screening process is not an evaluation or assessment. Rather, it is a brief, structured interview conducted either face-to-face or by telephone to determine whether or not the individual should be referred for further services and, if so, to where.

Assessment is a follow-up next step if screening indicates that assessment is needed. It could include an evaluation of the nature and extent of the individual's problem or disability through a

systematic appraisal of the person's mental, psychological, physical, behavioral, functional, social, economic and intellectual resources. Its purposes are diagnosis, determination of the person's disability level, eligibility to be included in a targeted population and an evaluation of the situation's urgency and intensity of need.

Referral means offering information about available qualified providers, generic resources and community capacity to best meet the needs of the individual. This information will also be used by local community systems to help determine gaps in service and network development.

Emergency triage and services include a range of functions including crisis response activities such as 24-hour crisis hotline and urgent or emergent clinic/practitioner visits, to be available both to people who initially enter the system in crisis and to those in target populations who are already receiving system services. Also included are other crisis stabilization interventions such as family/ caregiver respite, crisis shelters, detoxification services or emergency psychiatric hospitalization. These functions may not be located in every county; however, the services will be available for the public.

Care coordination as a core function means referring people not meeting criteria for public system eligibility but needing services, to appropriate community resources such as faith-based agencies, community organizations and 12-step self-help groups. It also refers to coordination of care for people, who may or may not be in target populations, who are being discharged from emergency or inpatient programs.

Service coordination is a separate and distinct administrative function. It involves ensuring that service elements throughout the region are seamlessly integrated, consistent in management policies and practices and consumer and family friendly. This is not the same as care management (a component of utilization management in managed care) or case management (a care-coordinating activity for specific individuals who are receiving treatment, services or supports within the system).

Consultation is provided to agencies, groups or organizations and to individual practitioners to promote planning and developing mh/dd/sa services. The local business plan will outline how the local service system will provide this service to the community.

Education is designed to inform and teach various groups including persons being served, families, schools, businesses, churches, industries, civic and other community groups about the nature of mh/dd/sa and services and supports in the state and community. The local business plan will outline how education will be provided.

Universal prevention is designed to inform and teach the population at large about insights and skills related to healthy living. The local business plan will outline how prevention will be provided.

UNIFORM PORTAL

Uniform portal is a term used to describe a set of standardized processes and procedures that ensures that people throughout the state enter and leave publicly funded services in the same way. The pathways to access (the core functions of screening, referral, assessment and emergency management) provide the framework for uniform portal activities. These pathways to access, coupled with procedures for system discharge, essentially define uniform portal. There will be many access points, but standards must be consistent.

Access points may include:

- Any public agency in the county (such as social services, vocational rehabilitation, schools, public health).
- A statewide referral service.
- Qualified service providers in the local network.
- Local management entity.

A uniform access system:

- Ensures availability of information about services.
- Facilitates access to available, timely and appropriate treatment or services.
- Provides standardized, consistently implemented, statewide procedures that comply with best practices and are understandable to consumers.
- Provides mechanisms for receiving and responding to feedback from people with disabilities, family members and other stakeholders.
- Provides consistent and coherent information.

Elements of uniform portal activities such as screening and eligibility determination instruments, documentation and reporting methods, referral process development, basic and extensive assessment procedures and others are under development by an implementation workgroup. Details on implementation activities can be found in the state strategic business plan described elsewhere in this State Plan revision.

STATEWIDE SYSTEM CONTRACTOR

A single, statewide contract will provide information and referral and a statewide crisis hotline and utilization management for certain high cost services. The contractor will support each LME by taking calls 24-hours-per day, seven-days-per-week, through a single, statewide toll-free telephone system. This will include patching crisis calls through directly to the LME or to the emergency/crisis

system within the region. The contractor will screen and refer people seeking help to system access points available in their local area and will provide LMEs with daily status reports of calls from specific areas. LMEs will be expected to assist the contractor in developing and maintaining a database of regional resources for referral.

The contractor will also provide utilization management (UM) for high cost services such as acute hospitalization, long-term facility placement, out-of-state placements or person-centered plans exceeding a fixed funding level. The contractor will have demonstrated competency at providing services to people with substance abuse, developmental disabilities and mental illness. The contractor will be reimbursed on a cost-plus basis and will have no financial incentive for denying care. The LME will provide all other utilization management. Utilization criteria will be established by the state, and the state will work with the contract agency and LME to promote statewide efficiency and consistency while recognizing the need for LMEs to have sufficient flexibility in how they structure the local service array to meet specialized needs. One or more LMEs who are in the first phase-in group may be selected to model or pilot full utilization management at the local level. Depending on the outcome of this demonstration, additional LMEs may be authorized to fully manage utilization in the second and succeeding three-year local business planning periods.

"Uniform portal needs to be more clearly defined. Without clear standards and definitions we are fearful that uniform will be anything but uniform."
State Plan feedback

SYSTEM ACCESS

Access to the service system will be available 24-hours-a-day, seven-days-a-week (24/7) through crisis phone lines and, if needed, face-to-face contacts. People seeking services for the first time will receive a brief screening using a single standardized process. Screening will determine the seriousness of a person's needs and whether the person should be referred for an assessment. Everyone should have access to a reasonable and responsible level of care.

The individual will be referred if he/she is eligible or could be eligible for services. If the ideal service is not available, interim services may be provided. Very brief services may be provided if the assessment determines that the individual is not in a target population for priority services, but needs services. However, this may not interfere with financing or cause delay in service delivery to target populations. Referral should be made to community-based agencies, self help groups, faith-based initiatives or other such resources developed by the LME as part of the local service network.

Emergency services include the 24/7-phone line provided by the centralized utilization management contractor, walk-in emergency/urgent care, crisis shelter/respite beds and psychiatric inpatient beds. Limited care coordination will be provided to non-targeted individuals discharged from an emergency service in order to assure appropriate follow-up by other community services such as an independently enrolled qualified provider, a community-based agency or a self-help group.

Discharged individuals who are part of target populations will be referred to the appropriate system of care.

TARGET POPULATIONS

Providing services to individuals with the most severe disabilities is the primary focus of the re-designed system. Appropriate criteria to identify individuals with various disabilities and the greatest needs include diagnostic and functional elements as well as circumstances unique to each individual. Availability and access to appropriate services that meet the needs of each person served shall also be considered. The urgency and intensity of needs chart (in appendix) will be applied throughout the system to establish a structured process for prioritizing services and/or managing waiting lists. Clinical diagnoses are made according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R). Classification for billing purposes is made according to the International Classification of Diseases (ICD-9).

> ***"We need much more clarity on who will be eligible for services and how eligibility determinations will be made."***
> ***State Plan feedback***

Minorities are disproportionately represented in the service system. Special efforts need to be made to serve minorities appropriately. Definitions of target populations have been adjusted in this revision based on questions and feedback from system stakeholders.

ADULT MENTAL HEALTH SERVICES TARGET POPULATIONS

Mental illnesses are disorders characterized by disturbances in a person's thoughts, emotions or behavior. The term mental illness *can refer to a wide variety of disorders, ranging from those that cause mild distress to those that severely impair a person's ability to function.*

The resources of the adult public mental health delivery system are targeted to adults with severe and serious mental illness. Within the resources available, the system will provide, at a minimum, a base level of service to all persons in the target population who seek services or who can be engaged through outreach activities. Additionally, as recommended in a study by the Public Consulting Group[1], priorities are established within target populations to guide development and the provision of specialty services and programs to people with the most significant disabilities. Recent advances in treatment for individuals with serious mental illness (SMI) and severe and persistent mental illness (SPMI) make it possible for individuals with these conditions to live far more satisfying lives than ever before. The system for adults with SPMI and SMI adopts a rehabilitation and recovery model focusing on providing or assisting individuals to obtain and maintain the skills they need to live as normally as possible in communities of their choice.

Adult mental health target populations for community services

Persons with severe and persistent mental illness

These are people who are 18 years or older and, resulting from a mental illness, exhibit functioning that is so impaired it interferes substantially with their capacity to remain in their communities. Their mental disability limits their ability to function in activities of daily living such as interpersonal relations, homemaking, self-care, employment and recreation. The following diagnoses are included: schizophrenia, schizoaffective and schizophreniform disorders, bipolar disorder, major depressive disorder and psychotic disorder not otherwise specified. Functional status is assessed using the Global Assessment of Functioning[2] (GAF).

People in this target population include:

- People newly admitted for services who meet the diagnostic criteria and who have an initial GAF score of 40 or lower.

  OR

- Current clients, as of July 1, 2002, who meet the diagnostic criteria, but did not have a GAF assessment when they were admitted, as a result of effective treatment do not currently meet criteria and without ongoing treatment and supports would likely experience greater disability and again meet level of functioning criteria.

  OR

- New clients who meet the diagnostic criteria but do not currently meet the GAF criteria and no previous GAF score is available, may be presumed eligible based on having a history of two or more hospitalizations, two or more arrests or homelessness.

Persons with serious mental illness

These are people 18 years or older who have a mental, behavioral, or emotional disorder that can be diagnosed and substantially interferes with one or more major life activities. These include delusional disorders, shared psychotic disorders, dissociative disorders, factitious disorders, obsessive-compulsive disorders, phobias, dysthymic disorder, borderline personality disorder, pedophilia, exhibitionism, anorexia, bulimia, post traumatic stress disorder, depressive disorder not otherwise specified, impulse control disorder and intermittent explosive disorder. Functional status is assessed using the GAF.

People in this target population include:

- People newly admitted for services who meet the diagnostic criteria and who have an initial GAF score of 50 or lower.

  OR

- Current clients, as of July 1, 2002, who meet the diagnostic criteria, but did not have a GAF assessment when they were admitted, as a result of effective treatment do not currently meet criteria and without ongoing treatment and supports would likely experience greater disability and again meet level of functioning criteria.

  OR

- New clients who meet the diagnostic criteria but do not currently meet the GAF criteria and no previous GAF score is available, may be presumed eligible based on having a history of two or more hospitalizations, two or more arrests or homelessness.

Priority populations within target populations

- Persons with multiple diagnoses*: Persons 18 or older with a severe and persistent mental illness and a diagnosis of substance abuse and/or mental retardation or serious health problem including HIV disease.*
- Persons who are homeless and mentally ill*: Persons 18 or older with a serious long-term mental illness or a serious long term mental illness and substance abuse diagnosis who lack fixed, regular and adequate nighttime residence.*
- Mentally ill adults in the criminal justice system*: Persons 18 or older with serious mental illness who are released from the Division of Prisons, or are in local jails or on probation.*
- Elderly persons*: Persons age 65 and over with a serious mental illness, including dementia.*
- Deaf mentally ill persons*: Persons 18 or older with a mental, behavioral or emotional disorder that can be diagnosed who need specialized services provided by staff who have American Sign Language skills and knowledge of deaf culture.*
- Minorities*: Adults with severe and persistent mental illness who are disproportionately represented in the system.*

Adult mental health target populations for state hospitals

In the next five years, state hospitals should revise their complement of beds and services to focus on their mission of providing psychiatric inpatient care to individuals with severe mental illness who cannot be appropriately treated in their local communities. Efforts already underway to prevent unnecessary institutionalization by directing people to local service providers whenever possible will continue.

Primary populations to be served among state hospitals

- *Adults with psychiatric illness* including schizophrenia spectrum, bipolar disorder, major depression, and some personality disorders, requiring brief acute inpatient treatment of a few days to stabilize and return to their communities.
- Adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression, and some personality disorders, requiring long-term inpatient rehabilitative treatment of approximately three to six months, to prevent or correct a rapid relapse and readmission cycle, or who remain dangerous to self or others.
- Children with severe emotional disorders requiring acute inpatient treatment to stabilize and return to a less restrictive environment.
- Older adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders requiring acute inpatient treatment to stabilize and return to their communities.
- Adults with psychiatric illness and substance abuse disorders, or serious illness such as HIV requiring acute and/or longer-term inpatient treatment to stabilize and prevent rapid relapse and readmission.

Specialty populations to be served

- Forensic patients, including those found incapable of proceeding with court trials (House Bill 95), not guilty by reason of insanity and other detainees.
- Patients taking part in a research protocol.
- Deaf consumers requiring acute or long-term inpatient psychiatric services.

Adult mental health target populations the NC Special Care Center

The NC Special Care Center's mission is to provide intermediate and skilled nursing care for individuals referred from state hospitals and for people who can't be served in their communities because of insufficient bed-space and insufficient psychiatric services of the intensity needed.

Primary populations to be served

- Consumers with severe mental illness requiring ICF level of nursing care (intermediate care facility).
- Consumers with severe mental illness requiring SNF level of nursing level care (skilled nursing facility).

Specialty population to be served

Consumers with mid-stage Alzheimer's disease requiring nursing care.

> *"Children with a serious emotional disturbance are persons from birth up to age 18, who are currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder meeting diagnostic criteria specified within the DSM-IVR, and that resulted in functional impairment that interferes with or limits the child's role or functioning in family, school or community activities."*
> *The Center for Mental Health Services*

CHILD MENTAL HEALTH SERVICES TARGET POPULATIONS

Target Population 1 (Severe)

Children with Serious Emotional Disturbance (SED).

- Children under 18 years of age with atypical development (up to age 5) or serious emotional disturbance (SED) defined by the presence of a mental, behavioral or emotional disturbance that can be diagnosed. These children will have priority if they are also identified as sexually aggressive and/or deaf and/or if they have dual or multiple diagnoses.

  AND

- Functional impairment that seriously interferes with or limits the child's role or functioning in family, school, or community activities as indicated by:

  - A Child and Adolescent Functional Assessment Scale (CAFAS) score of at least 90, or the total CAFAS score is greater than 60, but it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning.

  OR

- In need of services from more than one child-serving agency (e.g., MH/DD/SAS, Department of Social Services, Department of Public instruction/Schools (other than regular education), Department of Juvenile Justice and Delinquency Prevention, public Health, health care, other community organizations/providers) and informal supports and services.

AND

- Placed out of the home or at risk of out-of-home placement, as evidenced by any of the following:
  - Using or having used acute crisis intervention services in the past year or intensive wraparound services in order to maintain community placement.
  - Having had three or more state or private hospitalizations in the past year or at least one hospitalization of sixty continuous days.
  - DSS has substantiated abuse, neglect or dependency in the past year.
  - Been expelled from two or more daycare or pre-kindergarten programs in the past year.
  - Within the past year, convicted of a felony or two or more serious misdemeanors in juvenile/adult court or currently placed in a youth advocacy program (training school), prison juvenile detention center or jail.
  - Situation worsened by special need (such as chronic health conditions such as diabetes, deafness, sexually aggressive).

NOTE: *Must meet* ***Level D criteria*** *in the* Child Level of Care *document for specific services.*

Target population 2 (Moderate)
Children with SED (serious emotional disturbance)

- Children under 18 years of age with atypical development (up to age 5) or serious emotional disturbance (SED).

AND

- Have functional impairments that significantly interfere with or limits their role or functioning in family, school or community activities.
- Children with moderate functional difficulties in home, childcare, school or community activities that lead to a CAFAS score of at least 60, or a total CAFAS score that is greater than 30, but it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning.

NOTE: *Must meet* ***Level C*** *criteria in the* Child Level of Care *document for specific services.*

Target Population 3 (Deaf)

Children who are deaf and have SED (serious emotional disturbance) and a diagnosis of mental illness AND need specialized services provided by staff having American Sign Language skills and knowledge of deaf culture. These children must have a psychiatric disorder; however there is no specific requirement regarding function as measured by a CAFAS score.

Target Population 4 (Homeless)

Children who are homeless and have SED (serious emotional disturbance) and a diagnosis of mental illness AND who lack fixed, regular, adequate nighttime residence or have a primary nighttime residence that is a) a temporary shelter or b) temporary residence for individuals who would otherwise be institutionalized or c) a place that is not designed/used as regular sleeping accommo-

dations for human beings or are at imminent risk for homelessness. There is no specific requirement regarding function as measured by CAFAS score.

***Note**: Assertive outreach can be provided to homeless children who have not yet been diagnosed.*

DEVELOPMENTAL DISABILITIES SERVICES

Developmental disability *means a severe, chronic disability of a person that:*

- Is attributable to a mental or physical impairment or combination of mental and physical impairments.
- Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22.
- Is likely to continue indefinitely.
- Results in substantial functional limitation in three or more of the following areas of major life activity: self care, receptive and expressive language, capacity for independent living, learning, mobility, self direction and economic self-sufficiency.

  AND
- Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated.
- When applied to children from birth through four years of age may be evidenced as a developmental delay.

Developmental disabilities target population for community services

In the late 1980's, North Carolina adopted the federal functional definition of developmental disability, which in essence, targeted the population to those most impacted by disability. While this definition presumes that mental illness is not the cause or origin of the primary disability, it is acknowledged that those individuals who meet this functional definition may experience a co-occurring mental illness.

Developmental disabilities services are provided throughout a broad and diverse population. The target population is created by the application of a functional rather than diagnostic definition and is applicable throughout the lifetime of most individuals who are eligible for services. Since people with developmental disabilities, uncomplicated by secondary conditions, do not have an illness that is amenable to medical treatment, services and supports for these individuals focus almost entirely on interventions that strengthen the individual's ability to manage community living conditions and maintain or build a reliable personal support system.

All people currently in services meet the target population criteria, but they may be receiving services/supports inappropriate to their level of need. The requirement in the new system for re-

assessment of individuals already receiving services is to correct any mismatches that currently exist.

SUBSTANCE ABUSE SERVICES

Substance abuse target population

The most significant opportunity to reduce the burden of substance abuse on public programs is through targeted and effective prevention programs. If children can be kept from smoking cigarettes, using illicit drugs and abusing alcohol until they are 21, the risk for future addiction is substantially reduced. Treatment is also a cost-effective intervention, as it reduces the costs to state programs in the short term and avoids future costs. North Carolina will make targeted interventions for selected populations that hold promise for high return. As savings and new resources become available to expand service system capacity, additional populations will be added to the list of those targeted for services.

Target populations for substance abuse services (eligibility criteria)

All individuals will be assessed for service eligibility on the basis of the American Society of Addiction Medicine (ASAM) patient placement criteria for the treatment of substance-related disorders (PPC).

Injecting drug users, those with communicable disease and/or those enrolled in opioid treatment programs:

- Adults currently (within 30 days) injecting a drug under the skin, into the muscle, or into a vein for non-medically sanctioned use and meet criteria for a substance-related disorder.

  OR
- Adults infected with HIV, tuberculosis, or hepatitis B, C, or D and meeting criteria for a substance-related disorder.

  OR
- Adults who meet criteria for dependence to an opioid drug, are addicted at least one year before admission, are 18 years of age or older and are enrolled in an opioid treatment program.

Substance abusing women with children

- Women who meet criteria for a substance-related disorder (primary diagnosis for child only).

  AND
- Adults who are currently pregnant or who have dependent children under 18 years of age or who are seeking custody of a child under 18 years of age.

  OR
- Adolescents women who are currently pregnant or who have dependent children under 18 years of age.

DSS-involved parents who are substance abusers

- DSS involved adult parents who are substance abusers include those who have legal custody of a child or children under 18 years of age and who meet criteria for a substance-related disorder.

  AND

- Who are under active investigation or supervision by Child Protective Services for suspected or substantiated child abuse or neglect.

  OR

- Who are authorized by DSS to receive Work First assistance and/or services.

High management adult substance abusers

- Adults who meet criteria for a substance-related disorder.

  AND

- Are currently involuntarily committed to substance abuse treatment (legally determined to be dangerous to self or others and may have co-occurring mental illness).

  OR

- Have a substance use pattern of recurring episodes of habitual use with multiple documented unsuccessful treatment episodes that may include assisted detoxification, and who are advanced in their disease and who have no social or environmental supports and who have few coping skills and who may be highly resistive to treatment and who may have co-occurring disorders (excluding the severe and persistent mental illness (SPMI) and the serious mental illness (SMI) populations) and who may have moderate biomedical conditions.

Substance abusing individuals who are involved in the criminal justice system

- Adult or adolescent criminal justice clients who meet criteria for a substance-related disorder (primary diagnosis for child only).

  AND

- Whose services are authorized by a TASC Program Care Manager.

  AND

- Who voluntarily consent to participate in substance abuse treatment services.
- Primary substance abusing criminal justice populations include:
- Intermediate punishment offenders.
- Department of Correction releases (parole or post-release) who have completed a treatment program while in custody.
- Community punishment violators at-risk for revocation.

DWI offenders

- Adults or adolescents who are convicted of driving while impaired, commercial DWI or driving under 21 years of age after consuming alcohol or other drugs.

  AND

- Who have completed a DWI assessment and have been identified with a substance abuse handicap based on criteria for a substance-related disorder (primary diagnosis for child only).

  AND

- Who have paid the legislatively mandated fees for substance abuse assessment and treatment.

  AND

- Who have a family income of no more than the current federal income standard of 200 percent of poverty.

Deaf and hard of hearing

Adult clients who are 18 years or older and who have a substance-related disorder and who have been assessed as having special communication needs because of deafness or hearing loss.

Children and adolescents with primary substance-related disorders

Children and adolescents with a primary substance-related disorder.

Child substance abuse selective prevention

A child or adolescent under 18 years of age determined to be at elevated risk for substance abuse and who:

- Is currently experiencing documented school related problems or educational attainment difficulties including school failure, truancy, suspension or expulsion or dropping out of school

  OR
- Has documented negative involvement with law enforcement or the courts including formal and informal contacts such as arrest, detention, adjudication, warning, or escort.

  OR
- Has one or both parents, legal guardians, or caregivers who have one or more documented child abuse or neglect reports, investigations or substantiated incidents involving DSS.

  OR
- Has one or both parents, legal guardians, or caregivers who have a documented substance-related disorder.

Individuals do not meet criteria for a substance-related disorder or a mental health disorder, but may meet the criteria for other conditions that may be a focus of clinical attention. Recipients will be individually identified, client records will be maintained, and designated consumer prevention outcomes will be tracked.

Child substance abuse indicated prevention

Child or adolescent under 18 years of age who is using alcohol or other drugs at a pre-clinical level (child or adolescent does not meet criteria for a substance-related disorder or a mental health disorder, but may meet other criteria and who:

- Is currently experiencing documented school related problems or educational attainment difficulties including school failure, truancy, suspension or expulsion, or dropping out of school.

  OR
- Has documented negative involvement with law enforcement or the courts including formal and informal contacts such as arrest, detention, adjudication, warning, or escort.

  OR
- Has one or both parents, legal guardians, or caregivers who have one or more documented child abuse or neglect reports, investigations, or substantiated investigations involving DSS.

  OR

- Has one or both parents, legal guardians, or caregivers who have a documented substance-related disorder.

Individuals do not meet criteria for a substance-related disorder or a mental health disorder, but may meet other criteria. Recipients will be individually identified, client records will be maintained, and designated consumer prevention outcomes will be tracked.

Priorities within target populations

- Adult and child pregnant injecting drug users.
- Adult and child pregnant substance abusers.
- Adult and child injecting drug users.
- Children and adolescents who are involved in the juvenile justice or the social services system, who are having problems in school or whose parent(s) are receiving substance abuse treatment services.
- Adult and child deaf persons who need special services provided by staff who have American Sign Language skills and knowledge of the deaf culture.
- Adult and child clients who have co-occurring physical disabilities.
- Adult and child homeless clients
- All others.

Persons with substance abuse and mental illness

LMEs will be required to ensure that services are provided to individuals who experience substance abuse problems along with co-existing physical or cognitive disability. All services to adults with multiple disorders should address both the mental health and substance abuse needs in a coordinated, integrated manner. The primary responsibility shall be assigned as described here:

- Adult Mental Health Services shall have primary responsibility for mentally ill individuals who also abuse substances. *This includes adults who have a diagnosis of severe and persistent mental illness, including schizophrenia, bipolar disorder, schizoaffective disorder, recurrent major depression, or borderline personality disorder and in addition, have a substance abuse problem.*
- Substance Abuse Services shall have primary responsibility for consumers with substance abuse/dependence disorders who also have a mental illness. *This includes adults who carry a diagnosis of substance abuse/dependence and in addition and have a mental health diagnosis other than those listed above, which could include other Axis II disorders.*

Co-occurring disorders:

Individuals who meet the criteria for a target population often have more than one disability. People with severe and persistent mental illness, (or SED in a young person), may also have a developmental disability or mental retardation and/or a substance abuse problem. Such a pattern can occur among all disabilities in any combination, although the co-occurring disorder(s), taken alone, may not reach the level of a target population in the second category(s).

Generally, systems have done a poor job of recognizing and responding to these situations. Many organizations tend to focus their attention on specialized responses to a single disability – adult mental health, child mental health, developmental disability or substance abuse and fail to recog-

nize and address accompanying problems. Sometimes public funding mechanisms and budgetary rules get in the way of appropriately addressing all of an individual's needs.

The State Plan for system reform adopts a cross-disability approach that requires response to all of the conditions that affect successful community living. Clinicians must be able to assess for co-occurring disorders and treatment, and services and supports need to be integrated across all disabilities.

"Substance abuse and dependence is a complexdisorder, with associated biological, psychological, andsocial causes and effects. Historically, this disorder hasbeen treated as a social problem while the psychological andbiological aspects have been largely ignored. However, thedeterioration of functioning within each of these aspects requires that treatment and interventions address the entire biopsychosocial continuum. Substance abuse and dependence is progressive, chronic and relapsing. Although many of the symptoms and associated illnesses require that an individual receive specialized acute care, systems should also be prepared to treat the chronic elements of the illness. People with alcohol and drug abuse disorders are defined as individuals who meet DSM IVR diagnostic criteria for receiving intervention or treatment whether the nature of their presenting problem is biological, social, or psychological."
CSAT, November, 2000

[1] This study, commissioned by the NC Legislature, included detailed recommendations designed to make the overall mental health delivery system more responsive to the needs of North Carolinians..

[2] An assessment tool measuring the overall level at which an individual functions including social, occupational, academic, and other areas of personal performance and that may be expressed as a numerical score." (http://www.behavenet.com/capsules/disorders/GAF.htm)